CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	l` ′	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED		
		155277	B. WIN			08/16/2011		
		II	P. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER				CALUMET AVE			
WHISPE	RING PINES HEAL	TH CARE CENTER		1	RAISO, IN46383			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION	
TAG	•			TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE	
		,	1					
TAG F0000	This visit was for Complaint IN000 Complaint IN000 Federal/State def	094551- Substantiated, ficiencies related to the ted at F-282 and F-323. ency cited. agust 16, 2011 000176 155277 100288940 RN TC N	FO	TAG	This Plan of Correction constitutes the written alle of compliance for the deficited. However, submission that a deficient or that one was cited correction is submitted to meet require established by state and law. Whispering Pines de this Plan of Correction to considered the facility's A of Compliance. Complian effective on September 9	egation ciencies on of not an cy exists ectly. ments federal sires be llegation ace is	DATE	
LABORATOR		/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JJ1011

Facility ID:

000176

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277		(X2) MUI A. BUILD B. WING		OO	(X3) DATE S COMPL 08/16/20	ETED	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WHISPE	RING PINES HEAL	TH CARE CENTER			CALUMET AVE AISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T '	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	These deficiencies are cited in accordance with 410 IAC 16.2. Quality review 8/19/11 by Suzanne Williams, RN						
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical alter treatment significant in a exito adverse consequence form of treatment of the significant in the psychosocial statuconditions or clinical terms of the significant in the sin	nediately inform the with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or is in either life threatening cal complications); a need to inficantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident's physician;					
	resident and, if known representative or in when there is a chassignment as spead a change in reside	Iso promptly notify the own, the resident's legal nterested family member range in room or roommate ecified in §483.15(e)(2); or ent rights under Federal or ations as specified in of this section.					
	update the addres	ecord and periodically s and phone number of the presentative or interested					
	Based on interview and record review, the facility failed to notify		F01	57	F157 It is the policy of this facilit to develop, implement and enforce written policies and		09/09/2011
the physician of blood pressure				procedures to ensure a resid	ent's		

000176

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION OO		(X3) DATE SURVEY COMPLETED		
AND I LAN	or conduction	155277	A. BUI	LDING		08/16/2	
		155277	B. WIN	_		00/10/2	011
NAME OF	PROVIDER OR SUPPLIEI	R		1	ADDRESS, CITY, STATE, ZIP CODE		
WILLIODE	DINO DINECTICAL	TH CARE CENTER		1	CALUMET AVE		
WHISPE	RING PINES HEAL	TH CARE CENTER		VALPAR	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG		4-4:	DATE
	,	ent # C) and blood			physician and legal represen are notified if there is a chan		
		Resident # E) that fell			the resident's condition. I.		
	within call par	rameters for 2 of 4			Specific Corrective Actions		
	residents revie	ewed for physician			The nurses who did not follo policy and notify the physicia		
	notification in	a sample of 4.			the residents' low blood pres		
		P			were re-educated regarding		
	Findings inclu	ıde.			physician notification policy.		
					There was a new order rega	•	
	1 The clinics	al record of Resident #			blood sugars dated 4/27/11 t stated to notify the physician		
					blood sugar was greater than		
	C, reviewed on 8/16/11 at 2:00				350. Therefore, the nurses of		
	P.M., indicated diagnoses of, but				follow notification guidelines	in	
	not limited to: hypertension,				June and July regarding resi		
	dementia, and				E's blood glucose readings.	-	
		este op er este.			In-Service Notice and Physic Order dated 4/27/11] II.	lan	
		1 1 1 1 0 /0 /10			Identification and correctio	n of	
	1 -	Order, dated 8/8/10,			others: All residents have th		
	indicated, "Lis	sinopril 5 mg			potential to have a change ir	1	
	(milligrams),	Take 1 tablet by			condition that requires physic	cian	
		Metoprol Tar Tab 25			notification. All charts were	•	
		blet by mouth daily.			reviewed for orders related to blood pressure and physicial		
	1	•			notification if indicated by res		
	Hold if BP (bl	lood pressure) is <			and physician order. III. Sys t		
	(less than) 100	0/60 and notify"			Changes: All nurses attende	ed a	
					review of the Physician		
	Review of Re	sident # C's "Vital			Notification Policy where the		
					importance of following polic was stressed. [See In-Service	•	
	_	cord", indicated,			Notice] IV. Monitoring: The		
	"6/9/118 <i>A</i>	A.MBP			Managers will monitor existing	ng	
	90/546/11/1	13-11 (P.M.)BP			and new orders related to blo		
	95/526/22/1	18 A.MBP			pressures and audit charts a	S	
		3-11 (P.M.)BP			applicable for proper follow through on physician notifica	tion	
		<i>3</i> -11 (1 .lv1.)DF			if notification is required. Th		
	90/56"				be done daily for three month		
					then weekly for three months		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE : COMPL		
THIS TETRIC	or conduction	155277	A. BUI			08/16/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CALUMET AVE		
WHISPE	RING PINES HEALT	TH CARE CENTER		VALPAF	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	l `			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
PREFIX TAG	The clinical redocumentation notification of pressure value. During interviews 16/11 at 3:00 Resident # Crapressures for nadministration has a full set oblood pressure typically on sk She further incomplete would pertain taken. 2. Resident #E's reviewed on 8/16 indicated diagnost dementia, osteoarmellitus. A Physician's Ordinicated, "Notificated,	the above four blood s. ew with LPN # 2 on O P.M., she indicated equires daily blood		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
	for the months of indicated blood	FJune and July, 2011, glucose readings of over physician was not					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155277	B. WIN			08/16/2	011
NAME OF	DD OT HOED OD CLIDDLIE		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	ļ.	
NAME OF	PROVIDER OR SUPPLIEF	C		3301 N	CALUMET AVE		
		TH CARE CENTER			RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		1 at 12:00 P.M. = 349,					
		P.M. = 350, 6/03/11 at					
	8:00 P.M. = 348, 6/04/11 at 12:00 P.M. =						
	334, 6/16/11 at 12:00 P.M. = 338, 6/17/11						
	at $12:00 \text{ P.M.} = 1$	317, 6/19/11 at 5:00 P.M.					
	= 333, 6/22/11 a	t 12:00 P.M. = 327,					
	6/26/11 at 5:00 F	P.M. = 310 (A total of					
	nine times for th	e month of June). 7/02/11					
	at 12:00 P.M. = 1	307, 7/16/11 at 12:00					
	P.M. = 342, 7/18	8/11 at 5:00 P.M. = 350,					
	7/21/11 at 5:00 P.M. = 323, 7/23/11 at						
	5:00 P.M. = 311	(A total of five times for					
	the month of July).						
		57-					
	Nurse's Notes re	viewed for the months of					
		2011 did not indicate the					
	1	een notified of the above					
	elevated blood g						
	elevated blood g	lucose readings.					
	During an interv	iew with LPN #3 on					
	8/16/11 at 2:50 I	P.M., she indicated nurses					
		Nurse's Notes when they					
		n about a resident's issue.					
	A facility policy	titled "Physician					
		Change in Condition					
		2010, indicated, "Policy:					
	1 -	ysician is notified of					
	1 .	atient's condition as					
	1 .	ne nursing assessment					
	immediately upo	_					
	1	tification of physicians					
	1						
		al representatives will be					
	documented in the	he resident's clinical					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155277	B. WIN			08/16/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	CALUMET AVE		
WHISPE	RING PINES HEAL	TH CARE CENTER		l	RAISO, IN46383		
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TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
	record"						
	3.1-5(a)(2)						
F0282	The services provided or arranged by the						
SS=D	*-*-						
		n each resident's written					
	plan of care.						
		ation, interview and	F0	282	F282 It is the policy of this fa		09/09/2011
	record review, th	e facility failed to follow			to ensure services are provided by qualified persons in	iea	
	the Plan of Care	for a resident with a			accordance with each reside	nt's	
	history of falls, for	or 1 of 4 residents			written plan of care. Specific		
	•	re plans in a sample of 4.			Corrective Actions: The CN		
		real factor of the state of the			who left resident E alone in t		
	Resident: #E		bathroom on 7/30/11 was				
	Resident. πE				re-educated regarding residents		
	E' 1' ' 1 1				who are at high risk for falls a		
	Findings include				proper protocol. CNA #4 wa re-educated regarding explic		
					following the resident's care	-	
	Resident #E's cli				which stated "staff needs to s		
	reviewed on 8/16	5/11 at 12:25 P.M. and			with resident while toileting".	•	
	indicated diagnos	ses of, but not limited to,			August 1, 2011 summary,		
	dementia, history	of falls, osteoarthritis,			Progressive Discipline 7/30/	11	
	and diabetes mel	litus.			and Orientation List Fall		
					Prevention w/Renel 8/1/11 for Resident E's CNA on 7/30/11		
	A "Fall Risk Asso	essment," dated 4/05/11			CNA #4 see Progressive	, 101	
		/11, indicated Resident			Discipline 8/16/11 and Augus	st 29,	
	#E was a "High I	·			2011 summary] II. Identifica		
	πL was a IIIgII I	NISK 101 14115.			and correction of others: Al	II	
	A 3.1 3.1	1.7/20/11 1.7.20 P.3.5			residents, with a history of fa		
		ated 7/30/11 at 7:30 P.M.			have the potential to be affect		
		d to rm (room) by CNA			by failure to follow their plan care. All residents at risk for		
	` .	gaide). Res. on floor in			had their CNA sheets update		
	bathrm (sic) layir	ng on L (left) side, blood			indicate their fall risk and the		
	on floor under he	ead. Res. alert states 'My			plan intervention. III. System		
		•			Changes: All CNAs were		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	ETED
		155277	A. BUI B. WIN			08/16/20)11
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹					
WILLODE	DINO DINECHEAL	THE CARE OF MEET		1	CALUMET AVE		
WHISPE	RING PINES HEAL	TH CARE CENTER		VALPAR	RAISO, IN46383		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	nose is bleeding	, help me up.' Blood from			in-serviced on the new CNA		
	R (right) narel	aceration to (upper) of			sheets and the new policy		
	1 ` • ′	ng, hematoma to R			requiring them to carry the C		
	forehead with sm (small) amt (amount)				sheets, related to the resider		
					they are assigned to care for them while on duty. [See CI		
	bleeding" A radiology report, dated 7/30/11, for				Sheet Policy] IV. Monitorin		
					Compliance with the new po		
					will be monitored by the Unit	· .	
	Procedure: CT (computerized			Manager and/or designee. [
	tomography) sca	in indicated, "There is a			on each shift it will be verifie		
	minimally depressed fracture through the				each aide is carrying the CN		
	nasal bridgeA large soft-tissue				sheet for the residents assig		
					to them. After three months		
	hematoma overlies the frontal bone and				checks will decrease to weel	Kly	
	right periorbital	(eye socket) region"			checks. Monitoring will be reported monthly at the QA		
					Meeting. After six months th	ا م	
	Resident #E's Ca	are Plan, updated 7/30/11,			Quality Assurance Committe		
	indicated, "Prob	lem: (Resident #E) is at			decide if monitoring may be		
	risk for falls r/t (related to) history of			decreased or discontinued. [See	
	1	ety awareness and use of			CNA Sheet Audit tool]		
	- · ·	nedicationApproach:					
	_	stay with resident while					
		•					
	toileting. 8/01/1	I assist x I and					
	supervision."						
	LPN #3 indicate	d in an interview on					
	8/16/11 at 3:10 I	P.M., Resident #E had					
		n her bathroom on					
		er CNA left the room to					
	I	gown for her. When she					
		oom, she found Resident					
	#E lying on her bathroom floor and						
	bleeding.						
	During observat	ion of Resident #E on					
	_	P.M., CNA #4 took her					

000176

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155277	B. WIN			08/16/2	011
NAME OF T	DOLUDED OF GURNING		1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			3301 N	CALUMET AVE		
		TH CARE CENTER			RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		n and assisted her onto	1	IAG			DATE
	the toilet. CNA #						
		om, closed the door, and					
	waited for Reside	ent #E to finish.					
	ъ	:					
	_	iew with Resident #E's					
	POA (Power of Attorney) on 8/16/11 at						
	· ·	dicated she was told her					
	mother would not be left alone in the						
	bathroom without a staff person for supervision.						
		titled "Fall Prevention					
	_	April 2011, indicated,					
	"Purpose:To ic	dentify residents risk					
	factors and imple	•					
	measures when p	ossible to prevent					
	injuries10. Car	e Plan currency: a.					
	Identification of	risk/issued. Initiation of					
	preventive interv	rentions"					
	This federal tag r	relates to complaint					
	IN00094551.	•					
	3.1-35(g)(2)						
F0222	The feelite	manus that the master of					
F0323	•	nsure that the resident ins as free of accident					
SS=G		sible; and each resident					
	· ·	e supervision and assistance					
	devices to prevent	t accidents.					
	Based on observa	ation, interview, and	F0	323	F323 It is the policy of this facility to ensure that resident environments are free of accident		09/09/2011
	record review, th	e facility failed to					
	provide supervisi	ion for a resident with a			hazards, have adequate	iuciil	
	history of falls w	hich resulted in a			supervision, and proper assi	stive	

l i		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155277	B. WIN	IG		08/16/20	011
NAME OF I	PROVIDER OR SUPPLIEI	·	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF	ROVIDER OR SOLITEIE			3301 N	CALUMET AVE		
		TH CARE CENTER		VALPAF	RAISO, IN46383		
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	fractured nose, a laceration to the bridge				devices. I. Specific Correc	<u>tive</u>	
	of the nose requiring sutures, and several				Actions: The CNA who left resident E alone in the bathrough		
	large facial cont	usions. This deficient			on 7/30/11 was re-educated	OOM	
	practice affected	1 of 4 residents reviewed			regarding residents who are	at	
	with falls in a sa	mple of 4.			high risk for falls and proper		
		r			protocol. [See attachments l	isted	
	Resident: #E				for F282] II. Identification	and_	
	Resident. #E				correction of others: All		
					residents, with a history of fa		
	Findings include	2.			have the potential to be affect		
					by failure to follow their plan care. All residents at risk for		
	Resident #E's clinical record was				had their CNA sheets update		
	reviewed on 8/1	6/11 at 12:25 P.M. and			indicate their fall risk and the		
	indicated diagno	ses of, but not limited to,			plan intervention. III. Syst		
	dementia, histor	y of falls, osteoarthritis,			Changes: All CNAs were		
	and diabetes me				in-serviced on the new CNA		
					sheets and the new policy		
	A "Eall Dials Age	aggregat " datad 4/05/11			requiring them to carry the C		
		sessment," dated 4/05/11			sheets, related to the resider		
		0/11, indicated Resident			they are assigned to care for them while on duty. The Fal		
	#E was a "High	Risk" for falls.			Prevention Policy was revise		
					and all nursing staff were		
	Resident #E's m	ost recent quarterly MDS			educated on the revised poli	cy.	
	(Minimum Data	Set) Assessment, dated			[See CNA Sheet Policy, Fall		
	6/28/11, indicate	ed she was severely			Prevention Policy, and In-Se	rvice	
	impaired cogniti	•			Notice] IV. Monitoring:		
		ince of one staff person			Compliance with the new po		
		from one surface to			will be monitored by the Unit Manager and/or designee. [
	another.	from one surface to			on each shift it will be verified	, ,	
	anomer.				each aide is carrying the CN		
					sheet for the residents assig		
		e's Notes, dated 6/29/11 at			to them. After three months	the	
	1:30 P.M., indic	ated, "Res. (resident)			checks will decrease to weel	kly	
	found sitting on	floor of bathroom. Res.			checks. Monitoring will be		
	states that she w	as 'just trying to use the			reported monthly at the QA		
		ent completed, no s/s			Meeting. After six months th Quality Assurance Committe		
		oms) of injury notedwill			decide if monitoring may be	C MIII	
	1 (Signs of Sympto	ino, or injury noteswin			acolde il morilloring may be		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING ON COMPLE 08/16/20	
B. WING	, 111
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE	
WHISPERING PINES HEALTH CARE CENTER VALPARAISO, IN46383	
	(V5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
continue to monitor" decreased or discontinued. [See CNA Sheet Audit tool]	
A Nurse's Note dated 7/30/11 at 7:30 P.M.	
indicated, "Called to rm (room) by CNA	
(certified nursing aide). Res. on floor in	
bathrm (sic) laying on L (left) side, blood	
on floor under head. Res. alert states 'My	
nose is bleeding, help me up.' Blood from	
R (right) narelaceration to (upper) of	
nose with bleeding, hematoma to R	
forehead with sm (small) amt (amount)	
bleeding7:50 P.M. Notified Dr. (Name)	
of status. Order rec (received) to send to	
ER (emergency room) for eval	
(evaluation)8:45 P.MSm amt	
bleeding cont (continues) from R nare,	
sm. amt. bleeding from forehead and nose	
lac (laceration)Res. now c/o (complains	
of neck pain)9:30 P.M. Ambulance here	
to transfer to ER7/31/11 at 4:05 A.M.	
returned to facility with POA (Power of	
Attorney) via ambulanceBil. (bilateral)	
eyes with bruising"	
3:00 P.M. Purple bruising to face remains.	
Sutures to bridge of nose9:00 P.M.	
Edema (swelling) to nose. OU (both	
eyes) dark purple around"	
A radiology report, dated 7/30/11, for	
Procedure: CT (computerized	
tomography) scan indicated, "There is a	
minimally depressed fracture through the	
nasal bridgeA large soft-tissue	
hematoma overlies the frontal bone and	

000176

T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S COMPL	
	155277	B. WIN			08/16/2	011
PROVIDER OR SUPPLIER		•	3301 N	ADDRESS, CITY, STATE, ZIP CODE CALUMET AVE RAISO, IN46383	•	
SUMMARY S' (EACH DEFICIENCE REGULATORY OR right periorbital (LPN #3 indicated 8/16/11 at 3:10 P been left alone in 7/30/11 while her retrieve a clean g returned to the ro #E lying on her b bleeding. During observati 8/16/11 at 2:45 P into the bathroom the toilet. CNA # resident's bathroo waited for Resident Resident #E's Ca and updated 6/29 (Resident #E) is a to) history of fall awareness and us medicationApp tolieting (sic) q (e	TH CARE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) They socket region" If in an interview on I.M., Resident #E had In her bathroom on I.M. CNA left the room to I.M. CNA left the room to I.M. CNA #4 took her I.		STREET A 3301 N	CALUMET AVE		(XS) COMPLETION DATE
nursing aide). En wait for assist." Tupdated on 7/30/and 8/01/11 with approaches added	l w/CNA (with certified courage res. (resident) to The Care Plan was again 11 (after the 7/30/11 fall) the following new d: "Staff needs to stay the toileting. 8/01/11 pervision."					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155277	B. WIN			08/16/2	011
		l .	P. 1121		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			CALUMET AVE		
WHISPE	RING PINES HEAL	TH CARE CENTER		1	RAISO, IN46383		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During an interv	iew with Resident #E's					
	POA (Power of Attorney) on 8/16/11 at						
	4:00 P.M., she indicated she was told her						
	· ·	ot be left alone in the					
		it a staff person for					
	supervision.	at a starr person for					
	Supervision.						
	A C 1114 11	(AL 4 NE-11 D					
		titled "Fall Prevention					
	1 –	April 2011, indicated,					
		dentify residents risk					
	factors and imple	ement preventive					
	measures when p	possible to prevent					
	injuries. Purpose	e: It is the policy of					
		es Health Care Center to					
		ses and systems through a					
	1 ^	Program to provide for					
		residents in the facility,					
		•					
		The program will include					
		determine individual risk					
	of each resident	by assessing the risk of					
	falls, and implen	nentation of appropriate					
	interventions to	provide necessary					
		ndard Fall/Safety					
	_	all Residents:11.					
		equire staff assistance will					
		after being assisted to					
		_					
	bath, shower or t	wiici					
	This fall						
	· -	relates to complaint					
	IN00094551.						
	3.1-45(a)(2)						